MESABI RANGE COLLEGE

Athletic Physical Examination

(EXAMS MUST BE DONE BY A MEDICAL DOCTOR OR OSTEOPATHIC PHYSICIAN)

PLEASE PRINT

This form was developed in accordance with the NCAA Sports Medicine Guidelines and the AHA Recommendation for Cardiovascular Preparticipation Screening of Competitive Athletes

Name _____ **Date of Exam** _____

Date of Birth _____ **Age** _____ **Sex** _____ **Sport** _____

Height (inches) _____ **Weight** (lbs.) _____ **Brachial Blood Pressure (sitting position)** _____ **Pulse** _____

Vision Right 20/ _____ Left 20/ _____
Contact Lens: ❑ Yes ❑ No Color Blind: ❑ Yes ❑ No

Hearing (Whispered voice at 10 feet)
Right: ❑ Normal ❑ Abnormal
Left: ❑ Normal ❑ Abnormal

Clinical Evaluation

Normal	Abnormal	NOTES (Describe any abnormality in detail. Include results of any lab done.)
❑	❑	1. Scalp, Face, Neck, Thyroid _____
❑	❑	2. Nose and Sinuses _____
❑	❑	3. Mouth (tongue, gingivae,teeth) _____
❑	❑	4. Throat and Tonsils _____
❑	❑	5. Ears (tims and ext. canals) _____
❑	❑	6. Eyes (pupils, EOM conjunct.) _____
❑	❑	7. Lungs and Chest (include breasts) _____
❑	❑	8. Heart (rhythm, sounds, murmurs) _____
❑	❑	a. Precordial auscultation (supine) _____ (standing) _____
❑	❑	b. Assessment of femoral artery pulses _____ (to exclude coarctation of the aorta) _____
❑	❑	c. Physical stigmata of Marfan syndrome _____
❑	❑	9. Abdomen and Viscera _____
❑	❑	10. Hernia _____
❑	❑	11. Anus and Rectum (prostate if indicated) _____
❑	❑	12. Endocrine system _____
❑	❑	13. G-U System _____
❑	❑	14. Upper Extremity (shoulder, arm, wrist, hand) _____
❑	❑	15. Lower Extremity (hip, thigh, knee, ankle, foot) _____
❑	❑	16. Skin, Lymphatic Glands (cervical, inguinal, axillary) _____
❑	❑	17. Neurologic _____
❑	❑	18. Pelvic (if deemed necessary) Menstrual Cycle _____
❑	❑	19. Surgery(ies) _____
❑	❑	20. Other

Drug Allergies, Medications currently prescribed, etc.

_____

_____

_____

_____

(over)

Physician Recommendation

Please Complete

1. ❑ Approved for athletic participation **without** limitation.

2. ❑ Approved for athletic participation **with** limitation.
Specify: _____

_____

_____

_____

3. ❑ **NOT** approved for athletic participation.
Specify: _____

_____

_____

Printed Name of Physician: _____

Clinic Name/Facility: _____

Street/City/State/Zip: _____

Phone: _____ Fax: _____

Signature of Physician: _____ Date _____

Medical License #: _____

This form must be signed by an MD or DO.